DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Guidance to Physician/Practitioner and Supplier Billing Offices that Submit Hard Copy Claims to Medicare to Help Reduce Incidence of Claims Not Crossing Over Due to Duplicate Diagnosis Codes and Diagnosis Code Pointers

Provider Types Affected

This MLN Matters Special Edition (SE) Article is intended for physician/practitioner and supplier billing offices mailing CMS-1500 claim forms to Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article instructs physician/practitioner and supplier billing offices to correctly submit CMS-1500 claim forms to reduce the number of claims that are not "crossed over," or transferred electronically to the destination supplemental payer. Make sure your billing staff is aware of this guidance.

Background

Currently, when physician/practitioner and supplier billing offices mail CMS-1500 claim forms to their MAC or DME MAC, the MAC or DME MAC's shared system uses the resulting adjudication data in the creation of outbound Medicare crossover claims. More specifically, Medicare uses the results from the processing of the incoming hard copy claims to create outbound Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12-N 837 professional Coordination of Benefits (COB) claims.

After the incoming hard-copy claims have met their Medicare payment floor requirements, MACs and DME MACs then transfer these claims to the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC). The BCRC administers CMS' Medicare claims crossover process.

Upon receipt at the BCRC, the claims are edited for HIPAA ASC X12-N 837 claims compliance. Claims that pass compliance are "crossed over," or transferred electronically, to the destination supplemental payer. Claims that fail HIPAA compliance are not crossed over. Instead, the BCRC submits an electronic report to the associated MAC or DME MAC advising why the claims were not crossed over. MACs and DME MACs then create a notification letter that is mailed to the physician/practitioner or supplier's correspondence address of record, which is on file with the MAC or DME MAC. It is within the context of this process that CMS is creating SE1629.

Diagnosis Coding on Claims and Processing and Editing of Those Claims

Beginning in October 2015, billing vendors for physicians and medical practitioners and suppliers in the healthcare industry have been including International Classification of Diseases, Clinical Modifications, Version 10 (ICD-CM-10), on healthcare claims submitted to Medicare in association with specified Service-From Date requirements.

- Example: If a claim's Service-From Date is October 15, 2015, physicians/practitioners and suppliers are to bill the claim to Medicare using an ICD-10, rather than ICD-9, diagnosis code.

CMS MACs and DME MACs have either a front-end Contractor Common Edits Module (CCEM) or Common Electronic Data Interchange (CEDI) module that activates when ICD diagnosis code versions are incorrectly used for claim service dates. Additionally, the MAC and DME MAC CCEM and CEDI have logic that activates when incoming electronically-submitted claims contain duplicate ICD-10 diagnosis codes, as well as duplicate diagnosis code pointers.

MACs and DME MACs currently do not have established Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that may be used through Medicare's unprocessable claims procedure to advise physician/practitioners or suppliers that they have either incorrectly:

1. Included a duplicate ICD-10 diagnosis code on an incoming CMS-1500 Claim; or
2. Included a diagnosis code pointer reference more than once (for example, "1, 1") on such claims.

CMS is providing the informational guidance to physicians/practitioners and medical suppliers in the hopes that they will have fewer issues with Medicare crossing their claims over to supplemental payers.

BCRC Editing and Claims Failing to Cross Over

Prior to and after the implementation of ICD-10 diagnosis reporting in October 2015, representatives from the Medicare supplemental payer community informed CMS and its BCRC that the **ICD-10-CM, Version 5010 Manual** provides direction to users regarding the inappropriateness of reporting ICD-10-CM diagnosis codes more than once. The guidance is as follows:

Within Section B, "General Coding Guidelines, number 12, page 19," the Manual states, "**12. Reporting Same Diagnosis Code More Than Once**: Each unique ICD-10-CM diagnosis code may be reported only once per encounter. This also applies to bilateral conditions when there are no distinct codes identifying laterally or two different conditions classified to the same ICD-10-CM diagnosis code."

CMS has determined that the above guidance has influenced many healthcare plans, payers, and clearinghouses to create edits that will activate if the same ICD-10 diagnosis code is duplicated on claims. The BCRC, at the discretion of CMS, has also done so, to ensure that supplemental payers will not reject Medicare crossover claims with this characteristic upon receipt. Therefore, any claims that MACs and DME MACs transmit to the BCRC that contain duplicate ICD-10 diagnosis codes are encountering the following error:

- H54271 – "ICD-10 codes cannot be duplicated."

Since MACs and DME MACs have duplicate diagnosis code editing included in their CCEM or CEDI front-end editing routines, incoming electronic HIPAA ASC X12-N 837 claims with these characteristics are being rejected through Medicare's 277-CA process. This means it is primarily incoming hard copy (CMS-1500) claims that are now encountering the H54271 edit rejection.

Additionally, guidance in the HIPAA Technical Report Version 3 (TR-3) Guide governing 837 professional claims transactions makes reference to use of distinct diagnosis pointers to differentiate among multiple diagnosis codes when included on healthcare claims. It appears Medicare's CCEM or CEDI routines catch situations where diagnosis code pointer references are used more than once. However, there is no available CARC or RARC that can be used to identify this situation as part of Medicare's unprocessable claims procedure. Because of this, claims where a diagnosis pointer reference is duplicated, such as "1, 1," are encountering the following error at the BCRC:

- H25670 – "Diagnosis code pointers should not be duplicated."

Next Steps to Remediate This Issue

CMS recognizes it is possible for a physician/practitioner or supplier to reference a given reported diagnosis code, through a diagnosis code pointer, more than once when billing Medicare for multiple services on the same claim. However, vendors or physician/practitioner and supplier offices that create CMS-1500 claims can obtain better Medicare claims crossover results if they:

- Cease reporting the same ICD-9 or ICD-10 diagnosis more than once and
- Cease reporting a diagnosis code pointer reference more than once (for example, 1, 1, or 2, 2)

Additional Information

If you have any questions, please contact your MAC at its toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.

Document History

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